Advocating for Consumers in State Medicaid Managed Care Contracting

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Thank you for joining us. We will begin the webinar shortly.
Medicaid Managed Care and Mental Health Services and Pharmacy Benefits
Medicaid Refresher
Medicaid: Basic Facts

• Low-income individuals
• ~67 million beneficiaries
• Federal/state partnership
  – Managed separately by each state
  – Federal government matches state dollars, paying ≥50% of costs
  – 2009: $373.9 billion (15% of total US health expenditure)
Medicaid Eligibility

• Federally mandated Medicaid beneficiaries
  – Certain low-income children
  – Certain low-income parents
  – Pregnant women with income \( \leq 133\% \) of federal poverty level (FPL)
  – Elderly
  – Blind and disabled
• Some states opt to serve more people
• 2014: Target date for extended Medicaid eligibility
  – Almost all uninsured individuals
  – Families with income \( \leq 133\% \) of FPL
## Medicaid Services

<table>
<thead>
<tr>
<th>Mandatory</th>
<th>Optional</th>
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<tbody>
<tr>
<td>• Hospital services (ie, inpatient and outpatient)</td>
<td>• Prescription drug benefits</td>
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<td>• Physician services</td>
<td>• Dental services</td>
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<tr>
<td>• Laboratory and x-ray services</td>
<td>• Targeted case management</td>
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<td>• Nursing home and home health services</td>
<td>• Rehabilitation services</td>
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<td>• Prosthetic devices and eyeglasses</td>
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Medicaid and Mental Health
Mental Health in the United States

• 1 in 17 adults lives with severe mental illness (SMI)\(^1\)
• 1 in 10 children lives with a serious mental/emotional disorder\(^1\)
• People with SMI at increased risk
  – Additional chronic medical conditions\(^2\)
  – Shortened life expectancy\(^3\)

Medicaid is single largest payer for mental health services in the United States.


# Medicaid Mental Health Services

<table>
<thead>
<tr>
<th>All States</th>
<th>Majority of States</th>
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<tbody>
<tr>
<td>• Therapy and counseling</td>
<td>• Crisis intervention</td>
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<td>• Medication administration and management</td>
<td>• Mobile crisis services</td>
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<td>• Assessments, evaluations, and testing</td>
<td>• Crisis stabilization</td>
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<td>• Treatment planning</td>
<td>• Partial hospitalization</td>
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<td>• Emergency care</td>
<td>• Day treatment</td>
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<td>• Outpatient substance abuse (basic treatment and intensive services)</td>
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<td>• Ambulatory detoxification</td>
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<td>• Methadone maintenance therapy</td>
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Medicaid Mental Health Prescription Benefits: Open Access

- Although most states have provided largely unrestricted access to pharmacy benefits, they are increasingly looking to contain these costs.
- Cost-containment measures are of concern to advocates because mental health medications:
  - Are not clinically interchangeable
  - Work differently—even within the same drug class
- Physicians must have access to a wide range of options to ensure that they can find the appropriate medication and dosage level to treat each patient.
Medicaid Managed Care
Medicaid: Growth of Managed Care

• 2 divergent managed care trends
  – Declining in the commercial market
  – Increasing within state Medicaid programs
    • 71% of current beneficiaries\(^1\)
    • All states except Alaska, New Hampshire, and Wyoming\(^1\)
    • 42 states have \(\geq 50\%\) of beneficiaries in comprehensive managed care
      (including managed care organizations & primary care case management)\(^1\)

• Possible state goals for Medicaid managed care programs
  – Improved care management and coordination
  – Secure provider networks
  – Lower Medicaid spending
  – Predictable expenditures
  – Improved program accountability

Medicaid Managed Care and Mental Health

• Budget pressures have prompted states to expand their Medicaid managed care plans to patients with more serious conditions (eg, SMI, physical disability)

• Among disabled Medicaid beneficiaries nationally:
  – 58.4% enrolled in some type of managed care program¹
  – 28% enrolled in comprehensive, risk-based managed care programs¹

¹Medicaid and CHIP [Children’s Health Insurance Program] Payment and Access Commission (MACPAC), Report to the Congress: The Evolution of Managed Care in Medicaid, June 2011, http://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFLmdvdnxtYWNwYWN8Z3g6NTM4OGNnMTJiNjdiMDZiYWw.
Managed Care Plans

• Integrate the medical care and insurance systems

• Take different forms, but most plans:
  – Have a limited network of physicians
  – Require approval from primary care providers (PCP) before patients can see specialists

• Generally pay a set monthly fee per patient to PCPs for patient management services, regardless of amount of care provided
  – However, some plans also incorporate a fee-for-service (FFS) component
Medicaid Managed Care Responsibilities

• For program administrators, there are several areas of managed care responsibilities, including:
  – Quality assurance
  – Setting rates and monitoring claims
  – Customer service
  – Provider network management
  – Usage management
  – Data collection and analysis

Managed Care Models

• 3 basic managed care models are recognized by the Centers for Medicare and Medicaid Services
  – Comprehensive risk-based managed care plan
    • Managed care organization (MCOs)
  – Provider-based managed care
    • Primary care case-management (PCCM) plan
  – Limited benefit plan
Comprehensive Risk-based Managed Care Plans/Managed Care Organizations (MCOs)

- Can cover all (full-risk) or some (partial-risk) services
  - Fixed monthly amount (ie, capitation) paid to PCPs for covered services
    - Additional payments for other services on FFS basis
- Often health maintenance organizations (HMOs)
  - Members go to care providers who have contracts with the HMO
  - PCP gives basic care and referrals
- 2010: 35 states and DC contracted with MCOs
- 2009: 22 states and DC had >50% total Medicaid population enrolled in comprehensive risk-based managed care

2 MACPAC, Report to the Congress: The Evolution of Managed Care in Medicaid, June 2011, http://docs.google.com/viewer?a=v &pid=sites&srcid=bWFjcGFjlmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJiNjdkMDZiYw.
Risk-based Plans and Organizations by Level of Risk

• Full-risk plan
  – Federal government requires coverage of certain services
  – MCO bears entire risk (ie, cost) of patient services, whether more or less than expected are used
    • Discourages unnecessary procedures—but may also restrict use of some helpful but costly ones
    • Encourages use of preventive care
    • More predictable monthly expenditures for states

• Partial risk plan
  – Mixes capitation model with FFS
Primary Care Case Management

- PCP receives small monthly fee to coordinate each patient’s care
  - Some services provided on FFS basis
- 2010: PCCM used in 31 states\(^1\)
  - Popular as managed care model in rural areas
- Additional PCCM models
  - Enhanced PCCM – Wider range of services and greater care coordination via use of case managers; specializes in care for patients with chronic conditions
  - Patient-centered medical home – Expanded access and culturally effective care; PCP plus team of providers to customize care

Limited Benefit Plans and Administrative Services Organizations

• Limited benefit plan
  – Non-comprehensive – covers only one type of benefit (e.g., behavioral, dental, transportation, inpatient, ambulatory, substance abuse)
    • Used in conjunction with MCOs and FFS models
  – Capitated payments
  – May have more expertise than MCOs in meeting needs of particular beneficiaries (e.g., managed behavioral health organizations for people with SMI)

• Administrative services organization (ASO)
  – Manages claims and benefits
  – Optional services: Data reporting, care coordination, and/or customer service
  – Paid fixed fee
Mental Health Services and Prescription Benefits

• State Medicaid programs (or their MCOs) may separate 1 or both of these components from other healthcare services and/or pharmacy benefits, contracting (or subcontracting) them to:
  – Managed behavioral health organizations (MBHOs) or community mental health centers
  – Pharmacy benefit managers (PBMs)

• Medicaid prescription drug benefits for mental health medications vary widely among states, with some states being less/more restrictive
  – Approximately 20% of states currently “carve out,” or exclude, mental health drugs from MCO contracts\(^1\)
  – Drugs not on the state preferred drug list (PDL) often require providers to obtain prior authorization (PA)

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Pharmacy Benefit Managers

• PBMs may provide a wide range of services
  – Process claims
  – Discount drug prices by negotiating with manufacturers
  – Mail-order pharmacies
  – Negotiate supplemental rebates from manufacturers
  – Make recommendations to Medicaid Pharmacy & Therapeutics (P&T) Committees
  – Collect data and make recommendations to:
    • Healthcare providers (eg, prescribing practices, dispensing rules)
    • Patients (eg, disease-management tools)

• PBMs are usually paid a management fee rather than a capitation amount
Medicaid Prescription Benefits

• Optional service under federal Medicaid law
  – However, all states (to this point) have chosen to cover medications—at least to some extent

• States can opt to limit access to prescription drugs

• Prescription drug benefits
  – Can be eliminated without a federal waiver
  – Are most vulnerable to budget cuts and other attempts to restrict access
Mental Health Prescription Benefits

• Critical and integral part of medical treatment for people living with SMI
  – Difference between being a productive, fully engaged participant in a community and being institutionalized, incarcerated, or homeless

• Mental health treatment is highly effective
  – 70-90% of people with SMI can experience decreased symptoms and increased quality of life with the right pharmacologic, psychosocial, and supportive services¹
  – Improves health outcomes
  – Limits future use of expensive medical interventions

• Access to prescription drugs is crucial to:
  – Health and well-being of people living with SMI
  – Reducing overall Medicaid expenditures for this patient population

¹NAMI, Mental Illnesses – What is mental illness: mental illness facts, [date unknown], www.nami.org/template.cfm?section=about_mental_illness.
Cost-containment Strategies

• Drug benefits are extremely vulnerable to cost-containment measures such as:
  – PDLs and restrictive drug formularies
  – PA requirements
  – Cost-sharing arrangements
  – Medication dispensing limits
  – Requiring/incentivizing use of generic equivalents
  – “Fail first,” step therapy, or therapeutic substitution policies
  – Supplemental rebates
  – Multi-state purchasing coalitions
PDLs, Restrictive Drug Formularies, and PA Requirements

• States with PDLs in FY2011: 45 + District of Columbia¹
  – Approximately half of these states carve out whole drug classes for specific (generally costly) medical conditions, such as mental illness²
  – Restrict number and range of medications (formulary) for which Medicaid will pay
    • Create PDLs of medications that providers can prescribe without needing to obtain permission
    • HCPs must obtain PA for prescriptions not on the PDL

• Advocacy response
  – Shift costs to more expensive forms of “condition management” that are paid for solely by states
  – Patients with medication coverage gaps are:
    • 3 times more likely to become homeless³
    • 2 times as likely to be incarcerated³
    • In fact, inpatient mental health spending is nearly 40% higher in states with drug restrictions⁴
  – Consistent mental health medication access = Average monthly savings of $166 per patient⁵

Cost-sharing Arrangements

• Implemented by most states
• Shift some cost of medications back onto patients
• Most common form is copayment model (copays)
• Can be ≤20% of cost for beneficiaries with incomes >150% of FPL
• Advocacy response
  – Often a hardship for low-income beneficiaries
    • Save money primarily by discouraging beneficiaries from filling prescriptions at all
      – Can increase emergency room use by 88%¹
  – Do not generate significant state revenue
    • Patient copays are not federally matched, so copays do not offset a significant percentage of state costs
  – Increase state administrative costs

Medication Dispensing Limits and Mandated Generic Equivalents

• States with dispensing limits: 16\(^1\)
  – Restrict number of: prescriptions, pills, refills, and/or brand-name prescriptions

• States with generic drug rules: 22\(^2\)
  – Incentivize patients (eg, lower copay amounts) and providers/pharmacists (eg, higher reimbursements) to use generic equivalents because generics often cost 80-85% less than brand-name medications (before drug rebates factored in)\(^3\)

• Advocacy response
  – Numerical prescription limits
    • Pose significant challenges to people with multiple health issues (eg, comorbid SMI)
    • May not save money over long term; beneficiaries more likely to need more expensive medical care in the future as a result of deferred treatment
  – Generic equivalents are not available for newer drugs
  – Restricted access to new drugs can increase long-term costs
  – Interferes with provider-patient relationship

“Fail First”, Step Therapy, and Therapeutic Substitution Policies

• Require providers (fail first) and pharmacists (step therapy and therapeutic substitution) to prescribe/dispense the oldest and least expensive drug available first
  – Permission to move to a more expensive medication is granted only if the medication fails to help the patient

• Advocacy response
  – Mental health drugs are unique
  – Medication transitions can take 6-12 weeks¹
    • High risk of emergency department visits and hospitalizations²
  – Interferes with provider-patient relationship

Supplemental Rebates and Multistate Purchasing Coalitions

• In addition to the federal Medicaid rebate program, pharmaceutical companies cooperate in state-negotiated “supplemental” rebate programs, which include provisions for placing drugs on PDLs
  – States with supplemental rebates: 44\(^1\)
• States join multistate purchasing coalitions for greater bargaining power
  – States in multistate purchasing coalitions: 27\(^1\)
  – Advocacy response
    • Both models assume the use of PDLs and PA requirements, which restrict patient access to certain medications

Alternative Cost-containment Approaches

• Provider education and feedback programs
  – Review prescribing practices and pharmacy benefit claims
  – Promote best practices
  – Share data about drug effectiveness and costs

• Prescription case-management programs
  – Include features of provider education and feedback programs
  – Focus on long-term chronic condition management
Alternative Cost-containment Approaches (cont)

• Retrospective drug utilization review
  – Seeks to improve prescribing practices at the point of sale by preventing:
    • Therapeutic duplication
    • Overdosing
    • Drug interactions

• Value-based insurance design
  – Nets savings in health services for chronic conditions
    • Encourages use of “high-value” services (eg, medications) by reducing/eliminating patient cost-sharing arrangements and other obstacles to access
Transition From Fee-for-Service to Managed Care in Medicaid
Issues to Consider
Advocacy “Opportunity Points”

- During request for proposals (RFP) process when states move to managed care model
- State rule-making public comments
- State Medicaid waiver applications
- Medicaid Pharmacy and Therapeutics Committee meetings (e.g., PDL drafting process)
- MCO contract renewals
- Formal MCO member grievance procedures

The best way for mental health advocates to ensure that they have a voice in what happens with Medicaid is to develop and cultivate good working relationships with state Medicaid officials.
Key RFP Issues for Mental Health Advocates

• “Medical necessity”
  – Clear and broad enough definition to cover comprehensive mental health services
  – Experienced licensed clinicians should make necessity decisions using current clinical standards

• Covered services
  – Clear definitions that include: eligibility criteria and amount, duration, and scope of services
  – Prioritizes evidence-based, recovery-focused treatment
  – Consistent coverage decisions based on each patient’s needs

• Delivery of care and access to covered services
  – Clear timelines and waiting time standards
  – Meaningful language access for non-English speakers
  – Patients should have at least 2 providers in reasonable proximity
Key RFP Issues for Mental Health Advocates (cont)

• Network development and maintenance
  – Ensures availability of credentialed, culturally and linguistically competent mental health providers in all geographic areas

• Care management and coordination
  – Provides integration of mental health services with rest of health system
  – Guides patients regarding procedures for selecting PCPs, including how to select a specialist as PCP
  – Encourages care coordination

• Marketing activities, enrollment, and disenrollment
  – Defines permissible vs impermissible marketing activities
  – Specifies enrollment and disenrollment procedures
  – Ensures there is no discrimination regarding health status
Key RFP Issues for Mental Health Advocates (cont)

• Customer service and member education
  – Lists information members must be given (eg, member handbooks, confidentiality information)
  – Explains standard member inquiry procedures (eg, customer hotlines, ombudsman programs)

• Grievance and appeals processes
  – Includes easy-to-understand definition and explanation of these procedures in writing along with expected response times

• Quality assurance: Data collection and reporting
  – Conforms with federal and state-specified requirements, including publicly available reports
Key RFP Issues for Mental Health Advocates (cont)

• Payment and cost-sharing arrangements
  – Specifies capitation amounts and payment timelines
  – Ensures limited and clearly defined member cost sharing—especially for prescription drugs

• Utilization review
  – Describes permissible utilization review policies

• Enforcement, corrective action, and sanctions
  – Specifies enforceability mechanisms—including corrective actions and sanctions, which must be significant enough to encourage plan compliance
State and Federal Advocacy Tools

• Fact sheet
  – Reference document that describes the issue and provides relevant statistics and recent research highlights

• Organization sign-on letter
  – Template letter to lawmakers or policymakers to which multiple organizations are asked to add their endorsement

• Action alert
  – Time-sensitive request to contact public officials, etc.

• Constituent letter
  – Personal account sent to public official(s) from registered voter

• Talking points
  – A list of potential arguments and responses

• Op-eds/letters to the editor
  – Short articles or letters conveying a particular opinion about a cause

• Social media
  – Electronic platforms used to share information and mobilize advocates
References

• National Alliance on Mental Illness. NAMI reports deep flaws, money wasted in system designed to help persons with severe mental illnesses get jobs. 1997. www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=5315.
References

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Toolkit - http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/healthcare-reform